# Obstetrical Anesthesia

**Patient Information:** DOB: Age: Height: Weight:

**Date:**_____

Name:_____

Address:_____

_____

(City) (State) (Zip)

Telephone Home:(____)_____

Work:( )

SSN:_____

Due Date:_____

Obstetrician:_____

Spouse's Name:_____

**Current Medications:**

**Obstetrical History:**

# of Pregnancies:_____

# of Deliveries:_____ Vag____ C/S____

Past Delivery Dates: Anesthetic:

**Allergies:**

Medication: Y ◯ N ◯ Latex: Y ◯ N ◯

Reaction:

First Name

Last Name

| **Past Medical History:** | Y/N | Comments: |
|---|---|---|
| Hypertension | | |
| Heart Disease/Surgery | | |
| Lung Disease/Asthma | | |
| Diabetes | | Type: Treatment: |
| Thyroid Disease | | |
| Neurologic Disease | | |
| Seizures | | |
| Back Problems | | |
| Back Surgery | | |
| Scoliosis | | |
| Bleeding Hx. | | |
| Heparin or Lovenox | | |
| Aspirin | | |
| Skin Infection | | |
| Sleep Apnea/Snoring | | |
| Drug/Alcohol Abuse | | |
| Smoking Hx | | |
| Anesthesia Problems | | Family History?: |
| Other: | | |

**Prior Surgical History:**

Yes ◯ No ◯

| Procedure: | Anesthetic: |
|---|---|
| | |
| | |
| | |

Education

☐ Prior Epidural ☐ Anesthesia Brochure ☐ Anesthesia Video

☐ Anesthesia Website ☐ Prenatal Class